MAINE EMS
YOUR LIFE SUPPORT TEAM

EMERGENCY MEDICAL DISPATCH SERVICE CERTIFICATION APPLICATION

For what certification are you applying?

☐ 1. New Service Certification (Complete all sections of this application)
☐ 2. Change in Service Name or Change in Base Location (Complete sections I, V)

Section I - Service Information

A. EMD Service Name: _____ Service # (assigned by MEMS): _____

Mailing Address: _____ Shipping Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

County: _____ Business Telephone #: _____ Fax # _____

E-mail _____

EMD Card Set Used by the Service: ☐Medical Priority Dispatch (NAED) ☐PowerPhone ☐Maine/NECI

B. Please indicate the type of organization that will hold the service certification and check the legal status of the entity (a-h):

Legal name of entity that is applying for the certification: _____

Federal Tax ID# (EIN): _____

a. _____Municipal Fire b. _____Municipal EMS c. _____Municipal Police/Public Safety d. _____Other Municipal Gov't

e. _____ County Sheriff/Public Safety f. _____Other County Gov't g. _____ State Police/Public Safety h. _____Other State Gov't

Section II - Authorized Service Representatives (ASR)

List the names and telephone numbers of the EMD Director, as well as other Communications Supervisor(s) or other authorized representatives for the EMD service.

1. EMD Director: _____ Telephone # - (Day): _____ (Night): _____

2. Alternate ASR: _____ Telephone # - (Day): _____ (Night): _____

3. Alternate ASR: _____ Telephone # - (Day): _____ (Night): _____

4. Alternate ASR: _____ Telephone # - (Day): _____ (Night): _____

Section III Quality Assurance/Quality Improvement

List, by position (e.g. Director/Chief, Communications Supervisor, EMD), the members of your service and any outside partners involved in your EMD Quality Assurance/Quality Improvement, and attach a description of your service's quality improvement program.

_____ _____ _____

_____ _____ _____

Section IV - Personnel

List the (EMD) certified personnel for your service. Attach additional sheets if necessary.

Name	Maine EMD Cert.#		Name	Maine EMD Cert.#

Section V - Service Representative Endorsement

I hereby certify: that the foregoing statements are correct and true to the best of my knowledge and belief; that the service is eligible for certification/authorization in accordance with the Maine EMS Rules and EMS Law (32 M.R.S.A. §§ 81 et seq); that the service possesses the required equipment as set forth in the Maine EMS Rules; and, that the personnel providing medical care on behalf of the service possess current and valid Maine EMS certifications. Further, I request that the Maine EMS Board approve the Service's Quality Assurance/Quality Improvement Committee in accordance with 32 M.R.S.A. §92-A et seq.

Print Name of Service Director: _____ Signature: _____ Date:_____

Have You:

Completed the Application?
Attached All Required Documentation?
Signed the Application?

Mail your application package to:

Maine EMS
152 State House Station
Augusta, ME 04333- 0152

Tel. 207-626-3860